



DIVISION OF MEDICAL SERVICES PROVIDER BULLETIN

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PSYCHOTHERAPY BULLETIN PHYSICIAN (PSYCHIATRIST), PSYCHOLOGIST, PCNS, LCSW, LPC, FQHC, RHC

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PRIOR AUTHORIZATION FOR PSYCHOLOGICAL SERVICES FOR CHILDREN

Effective July 31, 2006, all current prior authorizations (PAs) for children age birth to 20 years will be terminated. New authorizations beginning August 1, 2006 may be requested via telephone at any time. The caller must have the information contained in the [Psychological Services Request for Prior Authorization Form](#) readily available. The Psychological Services Request for Prior Authorization Form must be used when requesting a PA by mail or by fax. If requesting continued treatment, the Psychological Services Request for Prior Authorization Form must be mailed or faxed and accompanied by the:

- Current Diagnostic Assessment
- Current/Updated Treatment Plan
- Last three Progress Notes reflective of therapy type being requested (i.e. requests for additional family therapy should include, progress notes from the three most recent Family Therapy sessions attended by the patient).

When requesting the initial PA by telephone, the form need not be used but all information on the form must be readily available to the caller. Requests may be made as follows:

Mail: Division of Medical Services
P.O. Box 4800
Jefferson City, MO 65102

Or

Phone: 866-771-3350

Or

Fax: 573-635-6516

Before requesting additional hours, 75% of the initial PA hours must be used. Hours used must be documented in the medical record. The PA approves the delivery of the requested service only and does not guarantee payment. The PA *must* be obtained prior to delivery of services. The patient must meet eligibility requirements on the date the service is provided and the provider must be enrolled and eligible to bill for the services.

PRIOR AUTHORIZATION LIMITATIONS BY AGE GROUP

Prior authorization of services for children will be based on the age of the child and the type of therapy requested. For children age birth through two (2) years of age, Family Therapy without Patient Present and Individual Interactive Therapy will not be allowed under the four (4) hours of non-prior authorized services.

Children Age Birth through 2 Years

Assessment for three (3) hours and/or Testing for four (4) hours will be authorized with submission of documentation. **Assessment and Testing for a child under the age of three (3) *must* be prior authorized and providers *must* submit clinical justification for providing these services.**

- Family Therapy will be authorized initially up to twenty (20) hours based upon the submission of required clinical documentation.
- Individual Therapy will not be authorized.
- Group Therapy will not be authorized.

Children Age 3 through 4 Years

- Family Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Family Therapy may be reauthorized up to fifteen (15) hours based upon the submission of required clinical documentation.
- Individual Therapy will not be authorized with the exception of Individual Interactive

Therapy, which may be authorized for up to ten (10) hours based upon the submission of required clinical documentation.

- Group Therapy will not be authorized.

Children Age 5 through 12 Years

- Family Therapy will be authorized initially for up to twenty (20) hours **without** submitting documentation.
- Family Therapy may be reauthorized for up to twenty (20) hours based upon the submission of required clinical documentation.
- Individual Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Individual Therapy may be reauthorized for up to ten (10) hours based upon the submission of required documentation.
- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Group Therapy may be reauthorized for up to ten (10) hours based upon the submission of required documentation.

Children Age 13 through 17 Years

- Individual or Family Therapy or a combination of both will be authorized initially for up to twenty-five (25) hours **without** submitting documentation.
- Individual or Family Therapy or a combination of both may be reauthorized for up to thirty (30) hours based upon the submission of required documentation.
- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Group Therapy may be reauthorized for up to ten (10) hours based upon the submission of required clinical documentation.

Children Age 18 through 20 Years

- Individual Therapy will be authorized initially for up to twenty (20) hours **without** submitting documentation.
- Individual Therapy may be reauthorized for up to twenty (20) hours based upon the submission of required clinical documentation.
- Family Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Family Therapy may be reauthorized for up to ten (10) hours based upon the submission of required documentation.
- Group Therapy will be authorized initially for up to five (5) hours **without** submitting documentation.
- Group Therapy may be reauthorized for up to ten (10) hours based upon the submission of required documentation.

CLINICAL EXCEPTION

The Division of Medical Services recognizes that there are rare instances in which psychological services may be authorized beyond the limits outlined above. For those persons who require additional therapy, Clinical Exceptions may be granted based upon documentation of extenuating circumstances.

NON-PRIOR AUTHORIZED HOURS

Providers may deliver four (4) hours of Psychological Services **without** prior authorization to a patient they have not provided treatment to within the last rolling year. The four (4) hours are intended to assist a provider seeing a patient for the first time in making the transition to PA should more than four (4) hours be required for treatment. The claims for the four (4) non-prior authorized hours should be submitted and payment received prior to submitting **claims** for any prior authorized hours/services. Providers who have been paid for services in excess of four (4) hours for a patient in the last year will not receive four (4) non-prior authorized hours for that patient. **Family Therapy without the Patient Present, Individual Interactive Therapy and all psychological services for patients age birth through 2 years are not included in the four (4) non-prior authorized hours and continue to require PA.**

ADEQUATE DOCUMENTATION

The Missouri Medicaid Program has specific requirements regarding adequate documentation that must be included in the medical record by the provider for the services rendered to a Medicaid patient. The Code of State Regulations, 13 CSR 70-3.030, Section (2)(A) has been **updated** effective November 30, 2005 to define "adequate documentation" more specifically. All providers should take note of this updated regulation as it will serve as a reference for criteria used to determine if documentation supports the code(s) or level of service(s) billed by providers. A provider's failure to furnish, reveal and retain adequate documentation for services billed to Medicaid can result in the recovery of the payments for those services not adequately documented and can result in sanctions to the provider's participation in the Missouri Medicaid program. This policy continues to be applicable in the event the provider discontinues as an active participating Medicaid enrolled provider as the result of a change of ownership or any other circumstance.

The Code of State Regulations, 13 CSR 70-98.015 establishes the regulatory basis for the documentation requirements of services provided through the Medicaid psychiatric/psychology/counseling/clinical social work program.

FAMILY THERAPY DEFINITION

Family Therapy is defined as the treatment of family members as a family unit, rather than an individual patient. When Family Therapy without the Patient Present (90846) or Family Therapy with the Patient Present (90847) is provided, the session is billed as one service (one family unit), regardless of the number of individuals present at the session. Providers may **not** bill for Family Therapy for each family member or configuration of members. This will be monitored by the Program Integrity Unit. Treatment of family members (adults) is **not covered** when provided by a Licensed

Clinical Social Worker (LCSW) or Licensed Professional Counselor (LPC) except when provided under Federally Qualified Health Clinic (FQHC) or Rural Health Clinic (RHC). Family Therapy furnished by an LCSW or LPC *must* be directed exclusively to the treatment of the child. **Parental issues may *not* be billed and Family Therapy is only billable when defined in the Treatment Plan as necessary on behalf of the identified patient.**

A Psychiatrist, Psychiatric Clinical Nurse Specialist (PCNS), or Psychologist may bill for services provided to an adult. When a family consists of a Medicaid/MC+ eligible adult and child(ren) and the therapy is *not* directed at one specific child, services may be directed to the adult for effective treatment of the family unit to address the adult's issues that impact the family. If the adult is *not* eligible and the family therapy is directed to the adult and *not* the child, the service may *not* be billed using the child's DCN.

Only one (1) prior authorization will be approved and open at a time for Family Therapy. If there is more than one eligible child and no child is exclusively identified as the primary patient of treatment, then the oldest child's DCN *must* be used for prior authorization and billing purposes. When a specific child is identified as the primary patient of treatment, that child's DCN *must* be used for prior authorization and billing purposes. Providers should *not* request more than one (1) Family Therapy prior authorization per family.

The definition of a "family" may be biological, foster, adoptive or some other family unit. **A family is *not* a group and providers may *not* submit a claim for each eligible person attending the same Family Therapy session. At least 75% of the session *must* have both child/children and parent(s) present.**

GROUP THERAPY DEFINITION

Group Therapy *must* consist of three (3) but no more than ten (10) individuals who are *not* members of the same family. This applies to inpatient Group Therapy sessions also.

Group Therapy may *not* be billed on the same date of service as Family Therapy (90846 or 90847) unless the patient is in an inpatient facility, a residential treatment facility or custodial care facility. *Services must be provided at the facility location.* Group Therapy in a group home is billed with POS 14. Group Therapy in a residential/custodial facility is billed with POS 33. Group Therapy in a shelter type setting is billed with POS 04.

ELECTRONIC SIGNATURE

Electronic signatures are paperless ways to sign a document using an electronic symbol or process. An electronic signature is an electronic sound, symbol or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record. Electronic signatures may be sent as part of an electronic transmission and are the legally binding equivalent of the individual's handwritten signature. Electronic signatures are accepted by Missouri Medicaid.

PLACE OF SERVICE 99

Effective for dates of service August 1, 2006 and after, the only valid setting for using place of service code 99 is a private school. Head Start is not considered a private school. Place of service 99 *cannot* be used for therapy provided in a public setting. A public setting includes but is not limited to: a parked or moving vehicle, library, park, shopping center or restaurant. Providers *must* use the appropriate place of service code for the setting in which services are rendered. **If there is no place of service code that matches the setting, services may *not* be billed to Medicaid.** Although there is a place of service 15 for mobile unit, Medicaid does *not* cover therapy services provided in this setting.

IMPLEMENTATION MAXIMUM MONTHLY BILLABLE HOURS

The Division of Medical Services Psychology/Counseling Program has implemented a monthly maximum of one hundred seventy-five (175) billable hours per provider effective August 1, 2006.

NPI-NATIONAL PROVIDER IDENTIFIER

Phase II of the National Provider Identifier (NPI), which includes provider type 49 - Psychologist, LCSW, LPC, Provisionally Licensed Clinical Social Worker (PLCSW) and Provisionally Licensed Professional Counselor (PLPC) will soon be implemented. Providers should monitor the Division of Medical Services website at www.dss.mo.gov/dms for future Missouri Medicaid Provider Bulletins and Hot Tips regarding the NPI Transition Project.

Provider Bulletins are available on the DMS Website at <http://www.dss.mo.gov/dms/providers/pages/bulletins.htm>. Bulletins will remain on the Published Bulletin site only until incorporated into the [provider manuals](#) as appropriate, then moved to the Archived Bulletin site.

Missouri Medicaid News: Providers and other interested parties are urged to go to the DMS Website at <http://dss.missouri.gov/dms/global/pages/mednewssubscribe.htm> to subscribe to the list serve to receive automatic notifications of provider bulletins, provider manual updates, and other official Missouri Medicaid communications via e-mail.

MC+ Managed Care: The information contained in this bulletin applies to coverage for:

- MC+ Fee-for-Service
- Medicaid Fee-for-Service
- Services not included in MC+ Managed Care

Questions regarding MC+ Managed Care benefits should be directed to the patient's MC+ Managed Care health plan. Before delivering a service, please check the patient's eligibility status by swiping the red MC+ card or by calling the Interactive Voice Response (IVR) System at 1-573-635-8908 and using Option One.

Provider Communications Hotline
573-751-2896